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The socio-economic and psychosocial impact of Covid-19 pandemic on urban refugees in Uganda

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ABSTRACT

Considering the COVID-19 global public health crisis, this paper examines the socio-cultural, economic and psychosocial impact of the pandemic on urban refugees in Uganda. We analyse the living conditions of urban refugees that make it problematic for them to adhere to public health measures. Since COVID-19 is perceived as “imported”, refugees are assumed as its potential transmitters, consequently experiencing heightened stigma and isolation. Lack of culturally and linguistically accessible information and services excludes them from on-going efforts to prevent the pandemic. The lockdown has affected refugee livelihoods and increased income insecurity, sexual and gender-based violence and anxiety. Given the paucity of government-led services to contain the epidemic, we argue that contingency planning must involve refugees and their communities to access accurate and relevant information in appropriate languages. It is also important to build the capacity of frontline workers to understand the specific needs of refugees to deliver appropriate protection in the context of the pandemic.

1. Background

As the world is grappling with the impact of COVID-19 pandemic, the 70.8 million refugees, displaced people and asylum seekers must not be forgotten. These are persons forcibly displaced due to persecution or conflict, human rights violations, environmental factors to name a few. Over 84 percent of the refugees are presently hosted by low or middle-income nations with poorer health systems (UNHCR, 2019a). Currently, Uganda hosts the third-largest refugee population in the world, and the largest in Africa. Most of the refugees are from neighbouring countries such as the Democratic Republic of Congo (DRC), South Sudan, Rwanda, Burundi, Ethiopia, Sudan, Eritrea, and Somalia (Mwenyango & Palattiyil, 2019). By September 2019, the country was hosting around 1.35 million refugees and asylum seekers, mostly in the West Nile, Northern, and Western parts of the country (UNHCR, 2019a). Majority of the refugee population are women and children (82 percent), around 56 percent of refugees are below the age of 15, while 25 percent are younger than 5 years of age (World Bank, 2019).

Uganda is considered to be one of the most conducive environments

in the world for refugees because refugees are allowed to set up businesses, offer labour services for others, and move freely in different spaces in the country (Crawford et al., 2019; Bohnet & Schmitz-Pranghe, 2019). As aptly stated by UN High Commissioner for Refugees, Filippo Grandi, the Uganda model allows refugees to work, cultivate the land, and to move around freely—rights rarely granted to that extent in other countries of first asylum, where the arrivals are typically viewed as competition for jobs and scarce resources (Bohnet & Schmitz-Pranghe, 2019; Tessa, 2018). Refugees also have access to government-provided health care and primary education.

The Uganda government's refugee policy stipulates that refugees should reside in officially demarcated settlements to access material support and protection (UNHCR, 2019b, p. 72). Therefore over 100,000 refugees living in different suburbs of Kampala city and other towns in Uganda that are not officially gazetted for refugee settlement have to find means to survive and meet their needs (Patton, 2016). Urban areas are an attractive proposition to these refugees because of prospects for employment, education and access to better infrastructure. Refusal to live in designated rural camps indicates that they preferred to use their skills

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to achieve sufficiency (Macchiavello, 2004; Patton, 2016). However, their time in urban areas increases their vulnerability to health challenges including COVID-19 due to limited economic opportunities for refugees, discrimination and inadequate housing (Stark et al., 2015).

On March 21, 2020, Uganda confirmed the first COVID-19 case and the number of cases have since then increased, albeit gradually (Atukunda, 2020, p. 1). Like other countries, authorities in Uganda put in place a lockdown that involved the closure of public places and the country's borders, social distancing, stay home except for emergencies, banning of public transport and instituted several public health measures such as washing hands often with soap and water for at least 20 s (especially after being in public places, or after blowing or sneezing and coughing), use hand sanitizers (containing 60% alcohol) and to avoid touching eyes, nose, and mouth with unwashed hands (Ministry of Health Uganda, 2020). Further measures were mandatory quarantine of suspected cases and people with recent travel history (Ministry of Health Uganda, 2020; The Republic of Ministry of Health Uganda, 2020).

As regards to humanitarian settings, the government suspended receiving new refugees and asylum seekers from 25 March for 30 days which led to the closure of all refugee reception centres at the border points and the Department of Refugees (DOR) offices in Kampala and Old Kampala Police Desk Refugee Office (Sebagoro, Nyakabande, Matanda, Elegu and Ntoroko) (The Republic of Ministry of Health Uganda, 2020). These measures are anticipated to reduce the spread of the virus and biomedical interventions. These measures are similar to those of many African countries that have adopted restrictive and combative public health measures aimed at enforcement of severe travel and mobility restrictions (Mbiyozo, 2020). While these measures may be broadly effective against the pandemic, they carry some risks particularly for vulnerable groups such as urban refugees (The Regional Risk Communication and Community Engagement (RCCE) Working Group, 2020). As the COVID-19 pandemic magnifies the pre-pandemic issues for various groups including women, minorities and refugees, it can easily intensify discrimination, stigma, poverty, unemployment and gender-based violence for the same. Although such have been a common feature during outbreaks in the past. The modern world, driven by complex political issues and uncontrolled information (circulated via online sources such as social media) escalates them. For instance, research from the United States of America indicates an upsurge in health care disparities between Blacks and Whites due to differences in exposure to adverse social determinants of health (Yancy, 2020). In addition to cardiovascular risk factors for minorities (Blacks), the low socioeconomic status especially in terms of poor access to quality housing and healthy foods has increased COVID-19 mortality among this group (Yancy, 2020).

The African Union in particular is concerned that vulnerable populations such as refugees and internally displaced persons might not access attendant human rights protected in the international law. These groups of people could have been already in transit when the COVID-19 outbreak occurred and are now trapped in areas including cities where lockdown or state of emergency have been declared (African Union, 2020). There is therefore a threat of neglecting the socio-economic and psychosocial aspects of the pandemic on the vulnerable population especially urban refugees. This article, therefore, examines the social, economic and psychosocial impact of the COVID-19 pandemic on urban refugees in Uganda.

2. Socio-cultural impact

Many urban refugees live in poorer urban suburbs of Kampala such as Kisenyi, Bwaise, Makindye, Nsambya, Kirombe and Kasaato with inadequate accommodation and public facilities (AGORA, 2018). Some urban refugees are homeless while others live in rented and crowded living conditions without access to water, sanitation and hygiene (WASH) facilities for good hand washing and hygiene practices that reduce transmission and exposure to the coronavirus (Mbiyozo, 2020). Stark et al. (2015) state that housing in these areas is congested and inadequate;

water and sanitation facilities are communal, and residents collect water from contaminated wetland springs (Stark et al., 2015). With restricted movements that have been imposed together with the stringent security measures that have been instituted to enforce adherence to the lockdown and curfew in Kampala, access to such communal sources of water may be further disrupted. This may be detrimental to the COVID-19 response given the critical importance of sanitation and more so of hand washing to the prevention of the disease.

According to the United High Commissioner for Refugees (UNHCR), refugees in all settings must be guaranteed their rights to safe, affordable, enough and continuous water to cover personal and domestic uses (UNHCR, 2019a). This is aligned with Sustainable Development Goal (SDG) 6 to ensure the availability and sustainable management of water and sanitation for all by the year 2030 (United Nations, 2015). Under such circumstances such as lack of access to proper WASH, refugees in urban centres may find themselves in challenging environments to adhere to public health measures, such as social distancing and self-isolation and enhanced hygiene (Kluge et al., 2020; Subbaraman, 2020).

The pandemic has increased social stigma and social isolation of urban refugees (United Nations, 2020a, 2020b, 2020c, 2020d). The fact that COVID-19 is perceived as "imported"; coming from either foreigners or nationals that travelled abroad makes the population and authorities suspicious of foreigners including refugees. This is contrary to the finding that the risk of disease transmission from migrants and refugees is minimal (Lancet Migration, 2020; Orcutt et al., 2020). In Uganda, the Ministry of Health has reported some cases of COVID-19 among refugees outside the settlements and some of their contacts (Orcutt et al., 2020). As a result, refugees are among those perceived as migrants, travelers and potential carriers or transmitters of COVID-19 among whom the risk of discrimination and stigmatization against refugees by the local people and authorities (such as community leaders, health workers, and representatives of organisations working with refugees in cities like Kampala and Arua) has been exacerbated (Castro & Lozet, 2020). This is regardless of reports by the government stressing that refugees who are already in Uganda would receive the support and solidarity consistent with the Ministry of Health's guidelines (UNHCR, 2020a). Research indicates that stigma limits compliance with established control measures, health-seeking, and access to services and may lead to further spread of the virus (Manderson & Levine, 2020, pp. 1–4; WHO African Region, 2018).

Limited access to information and national response plans due to the language barrier exacerbates the risk of urban refugees to COVID-19 (Malaba, 2020). The refugees' right to information concerning prevention and protection from the COVID-19 is curtailed by language and communication barriers. The fact that most refugees do not understand English and the major local languages means that they do not get first-hand and timely information about COVID-19 (Kasozi, 2018; Leter & Gatkuoth, 2020). Urban refugees mainly speak Arabic, French and Swahili which limits their comprehension of the governmental directives, public health messages as well as information, education and communication messages (Kasozi, 2018; Nantume, 2018; UNFPA, 2018). This exposes them to the risk of getting inaccurate information from peers and networks. It also excludes them from on-going efforts to prevent and control the pandemic. Yet as argued by the World Health Organisation (WHO), lack of culturally and linguistically accessible information and services related to COVID-19 may increase risks of contracting and spreading the virus among vulnerable populations (Kluge et al., 2020). Moreover, Uganda's strategic response to the pandemic is based on self-reporting based on the occurrence of symptoms. This is challenging for refugees who already are frightened of approaching health providers and local authorities coupled with limited knowledge of their health rights (Kasozi, 2018; O'Laughlin et al., 2018).

Besides, the lockdown has reduced access to services (such as reproductive, maternal, new-born and child health interventions and psychosocial support services) provided by several humanitarian

organisations (Castro & Florence, 2020). In Uganda, Civil Society Organisations (CSOs) play a pivotal role in providing the much needed reproductive health and psychosocial support services targeting vulnerable population groups including urban refugees (Omata & Kaplan, 2013a, 2013b). However, during the lockdown, services of the CSOs were not classified as essential by the governmental decree to lock down non-essential services (Omata & Kaplan, 2013a, 2013b). For instance, personnel working for most CSOs did not receive special travel permits and the closure of public transport posed an enormous challenge for humanitarian workers, who face increasing travel restrictions (Uganda Network of Young People Living with HIV & AIDS, 2020). While essential to reduce exposure and prevent the spread of the virus, this is problematic for most vulnerable refugees such as women and children who have limited options. Moreover, refugees including adolescents, children, pregnant women and those with chronic illnesses, such as those living with HIV and AIDS, are at risk of reduced access to medicines and care (Uganda Network of Young People Living with HIV & AIDS, 2020; United Nations, 2020a, 2020b, 2020c, 2020d).

3. Economic impact

The lockdown in a bid to reduce the spread of COVID-19 has affected refugee livelihoods and created income insecurity among urban refugees (United Nations, 2020a, 2020b, 2020c, 2020d). This is because urban refugees depend on the informal market economy and small enterprises such as artisans, tailors, hairdressers, traders in precious metal and diamonds and vendors of food and second-hand clothes (Macchiavello, 2004). The lockdown directives did not exonerate these small enterprises and has led to income insecurity (The Observer Team, 2020). Although this is perceived as a general problem in low and middle-income countries, given the high rate of unemployment in Uganda and it is among countries affected by extreme poverty, the situation is difficult for refugees who lack contingency livelihoods and social support networks that can serve as shock absorbers and coping resources. Low household income forces poor families to reduce expenditure on essential health items such as food and medicine (United Nations, 2020a, 2020b, 2020c, 2020d). This has been aggravated by the negative effect of COVID-19 on social support networks for urban refugees (United Nations, 2020a, 2020b, 2020c, 2020d).

In the first place, displacement weakens their original support network such as immediate and extended family support. It is estimated that the majority of urban refugees depend on remittances from relatives outside Uganda such as Sweden and the United States of America (Macchiavello, 2004; Omata & Kaplan, 2013a, 2013b). However, the lockdown in several countries implies that their informal social support systems through remittances (such as cash transfers) have been affected by job losses in many countries in the North where their relatives are living and working due to COVID-19 (Nowegian Refugee Council, 2020). For example, The World Bank (2020) has projected that global remittances are to decline sharply by about 20 percent in 2020 due to the economic crisis induced by the COVID-19 pandemic and lockdown (The World Bank, 2020). The projected fall, is largely caused by fall in the wages and employment of migrant workers, given that they tend to be more susceptible to loss of employment and wages during an economic crisis in a host country (Giulietti Assumpção, 2019). This has affected the amount and frequency of remittances they get as a source of livelihood and financial lifeline for the most vulnerable.

3.1. Gender relations and gender-based violence

There is a reported increase in sexual and gender-based violence (SGBV) including physical, sexual, emotional and economic violence and its health and psychosocial effects (Nakalembe, 2020). For example, the UN-Women has noted that the “COVID-19 pandemic is a global crisis that risks exacerbating gender inequalities as well as violence against women. As in past pandemics, there are clear signs women continue to bear the

brunt of emergent risks to public health, safety, and human rights” (United Nations, 2020a, 2020b, 2020c, 2020d). This is because the lockdown has challenged the traditional gender roles in terms of men being the main breadwinners for families. For instance, the closure of markets interrupted the work of male refugees who previously operated as vendors/small scale retailers. Consequently, such a sudden loss of work has resulted in a lack of income to support their children and women under their care (Peterman et al., 2020). This causes anger and frustration within families which aggravate emotional and physical violence. Lockdowns amidst economic hardships for families are associated with an increase of violence and abuse especially for dependants such as children (United Nations, 2020a, 2020b, 2020c, 2020d). Although female refugees would supplement the family income, these regularly work in the traditionally female-dominated informal economy such as braiding hair, washing clothes and tailoring (Macchiavello, 2004; Omata & Kaplan, 2013a, 2013b). These have however, also been closed during the lockdown but without providing any social protection to mitigate the effects of loss of livelihoods. Social distancing directives also indicate that such workers (i.e. female refugees) are no longer welcome in the places (including households) where they previously worked as casual domestic workers.

With no livelihood options and lack of social support, sexual violence and commercial sexual exploitation of refugee women and adolescents are almost inevitable (UN Women, 2020). The closure of informal trade can contribute to female refugees taking up survival sex to support their families (UNHCR, 2020b). This exposes them to HIV/AIDS and other sexually transmitted infections and increases the rates of unwanted pregnancies among refugees especially in the context that access to reproductive health services is constrained due to the reduction in services provided by CSOs and humanitarian actors due to the lockdown measures and banning of public transport that would have allowed them to access such services (UN Women, 2020).

4. Psychosocial impact

While social protection as an agenda for reducing vulnerability and risk of low-income households concerning basic consumption and services has become an important part of development discourse, the current social protection especially social assistance instituted by the government of Uganda is not adequate to the situation and needs of urban refugees in the context of COVID-19. This is contrary to Article 3 of the Universal Declaration of Human Rights which states that “everyone has the right to life, liberty and security of person” (Tomuschat, 2008). For example, the targeting criteria for entitlement to food support/distribution to the vulnerable populations affected by COVID-19 do not explicitly target urban refugees. The ongoing food distribution to support the poor and vulnerable urban residents affected by the lockdown requires people to present national identification cards that refugees do not have. Instead, refugees in Uganda have attestation cards (Omata & Kaplan, 2013a, 2013b).

Unlike refugees living in organised settlements supervised by the Office of the Prime Minister (OPM)—the entity in Uganda in charge of refugees, urban refugees are not benefiting from the current food distribution which jeopardies their wellbeing and coping capacities. This renders urban refugees and their families more vulnerable to lack of food and its associated consequences including starvation and malnutrition. It also increases their anxiety, stress, exclusion and other psychosocial problems particularly in the context of COVID-19 (United Nations, 2020a, 2020b, 2020c, 2020d). Further, there is heightened anxiety and stress due to public health measures such as ‘stay at home’ and curfew on movement from 7 p.m. to 6.30 a.m., which denote confinement in limited spaces. Moreover, closure of schools as part of lockdown has caused childcare pressures and an increase in family bills such as food, water and electricity because children are on extended holidays.

While the pandemic is spread by lack of clean water and sanitation facilities (SDG 6), as earlier stated, discrimination in food distribution

reverses progress in achieving food security (SDG 2) and other SDGs such as decent work and economic growth (SDG 8), access to education (SDG 4), reduced inequalities (SDG 10), extreme poverty (SDG 1) and above all, good health and wellbeing (SDG 3). Moreover, refugees are known to gather in social circles to interact with people who share commonalities and similar experiences (Kluge et al., 2020). Religious places such as mosques and churches provide refuge to cope with life in displacement (such as deprivation and stress). Restriction of social gatherings and closure of community-based support is another challenge to their emotional and psycho-social support.

4.1. Recommendations

The psychosocial and economic impacts of COVID-19 to the urban refugees in Uganda have led to posing the question of what we should do to protect vulnerable refugees from suffering harm during the lockdown. Some measures can be put in place to address concerns related to the COVID-19 pandemic among urban refugees.

Firstly, contingency planning for Uganda must involve refugees with no risk of financial or legal consequences for them. Humanitarian workers should be allowed protected access to the most vulnerable refugees. Working together with local leaders and refugee leaders, they should identify the most vulnerable individual refugees and families. Like other vulnerable Ugandans, urban refugees should benefit from government assistance in the form of food and other essential items distributed by the National Task Force on COVID-19.

Government authorities such as the Kampala Capital City Authority and other municipalities hosting urban refugees should work together with humanitarian organisations such as UNHCR, IOM and UNICEF to ensure continued availability and access to WASH services. In doing so, there should be a plan of water supply using trucks in places where refugees stay together with provision of sanitizers and soap.

It is important to build the capacity of frontline workers such as health care staff and other social care workers (such as social workers) to understand the specific needs of refugees so that they deliver appropriate protection to refugees both in short- and long-term periods of the pandemic. For instance, the use of any social media/telephone services around psycho-social support and different needs is important.

Correspondingly, the government must ensure the equitable distribution of health care and other material support such as food, soap and water. Besides, community engagement is vital to increase access to information about control measures, address stigma surrounding COVID-19 and comply with the control measures.

Refugees must have access to accurate and relevant information in appropriate languages. This should be complemented by radio announcements, posters and leaflets in the languages used by refugees such as French, Arabic and Swahili. This leads to the full inclusion of refugees in national preparedness, prevention and response measures to the COVID-19 pandemic.

Public health intervention should embrace programmes to sensitise the public and communicate important prevention measures to refugee communities. This is essential to dispel myths, misconceptions and misinformation about COVID-19 that exacerbate discrimination and hamper the adoption control measures.

Access to psychosocial support and mental health support such as online and telephone counselling sessions with individuals and families and virtual referral services will go a long way in addressing anxiety and stress related to the COVID-19 outbreak.

Although it is the responsibility of the host government to support refugees, we argue that social workers together with other professionals could contribute to supporting and protecting the most vulnerable refugees given the paucity of government protective services. Such interventions could range from conducting online and telephone counselling sessions for traumatised refugees to overcome anxiety, to carry out child abuse inquiries to ensure their protection from violence. Further, social workers could help create linkages between affected

refugees and available services and make appropriate referrals to government and non-government assistance programmes or even rehabilitation support for victims of COVID-19.

5. Conclusion

The COVID-19 pandemic has revealed the vulnerabilities urban refugees in Uganda are facing and this is indicative of what other urban refugees in Africa are experiencing. Consequently, as Uganda battles the COVID-19 pandemic, preparedness and response should be holistic taking into account the entire population including urban refugees. Special cognizance of the plight of the refugees is important given their vulnerability and unique circumstances. A holistic response to this pandemic demands appreciation of the psychosocial and socio-economic impact of COVID-19 to all vulnerable groups including urban refugees. Sub-optimal attention to the plight of urban refugees during preparedness and response plans for COVID-19 pandemic will not only exacerbate the devastating impacts of COVID-19 to this group but also poses greater risks and challenges to the host communities. This call embraces the principle of 'leaving no one behind' that is promoted by the United Nations (Lancet Migration, 2020). The aspiration for normalcy by the general population may not be achieved if a certain section of the population—the urban refugees in this case, is left behind. This is a central pledge of the UN's 2030 Agenda which aims at ensuring that all goals and targets are met for all nations and peoples without discrimination according to race, gender, disability, socio-economic status and nationality (United Nations, 2016).

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Paul Bukuluki: Methodology, Investigation, Supervision, Writing - review & editing. **Hadijah Mwenyango:** Methodology, Investigation, Writing - original draft. **Simon Peter Katongole:** Methodology, Writing - review & editing. **Dina Sidhva:** Conceptualization, Writing - review & editing. **George Palattiyil:** Conceptualization, Methodology, Supervision, Writing - review & editing.

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